

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

16184

**1. PLACE OF DEATH**

County..... Registration District No. 79  
Township..... Primary Registration District No. 1008  
City St. Louis (No. Mo. Baptist Sept)

File No.....  
Registered No. 4219  
St..... Ward)

**2. FULL NAME** John Corless

(a) Residence. No..... St., 17 Ward, Chesterfield Mo.  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma A. Corless

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
60 3 2

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis Co. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Cornelius Corless

11. BIRTHPLACE OF FATHER (CITY OR TOWN) England  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Pauline Ludwig

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis Co. Mo.  
(STATE OR COUNTRY)

14. INFORMANT Emma A. Corless  
(Address) Chesterfield Mo.

15. FILED 100 - 9 10 1929 REGISTRAR W. C. Starnes

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1929 to April 8 1929 that I last saw him alive on April 8 1929, and that death occurred, on the date stated above, at 5:40 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

1. Carcinoma lower sigmoid

(duration) ..... yrs. 6 mos. .... ds.

CONTRIBUTORY (SECONDARY) Carcinomatous

(duration) ..... yrs. 2 mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? no DATE OF Nov 6 - 1929

WAS THERE AN AUTOPSY? no

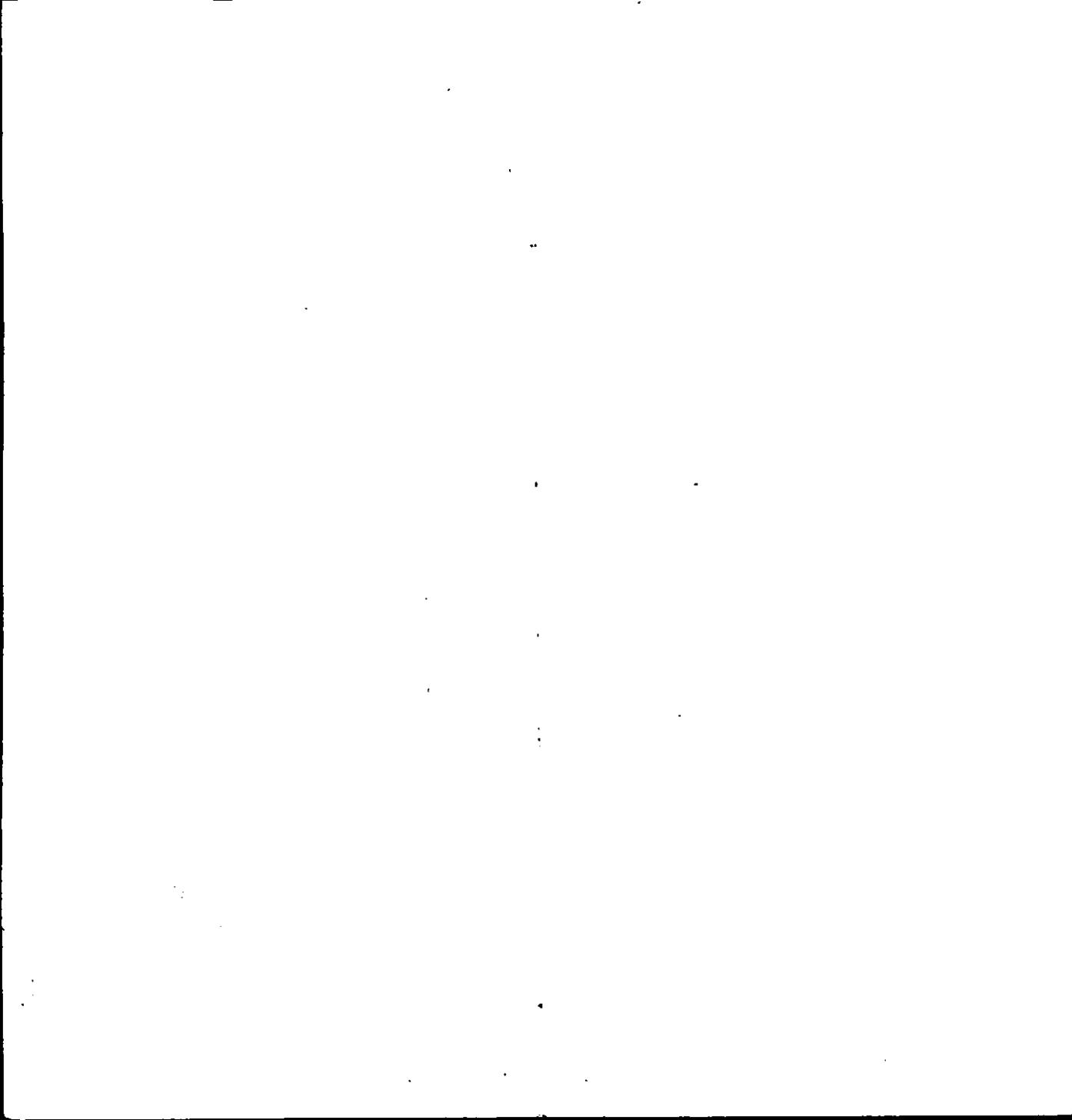
WHAT TEST CONFIRMED DIAGNOSIS operation X-ray -  
(Signed) Joyce Magidson, M. D.

April 9, 1929 (Address) 836 University Club Bldg -

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Opwille Mo. Antioch Cem. DATE OF BURIAL Apr 11 - 1929

20. UNDERTAKER Schradner Mtd. Co. Ballwin Mo.



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No. ....  
Township..... Primary Registration District No. 100-3 Registered No. # 2 19  
City St. Louis (No. ....) St. .... Ward)

**2. FULL NAME**

John Corless  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 - 1868

7. AGE YEARS MONTHS DAYS IN LESS than 1 day, .... hrs. or .... min.  
60 3 2

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED III - 99 1929 May 2 Stark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 8 1879

17. I HEREBY CERTIFY that I attended deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) .... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Schradel & Co Balwin Mo

SUPPLEMENTARY

68171-5